VT Assistive Technology Program Intake Form

Please provide the information requested below to aid us in supporting the services that are needed. The more information we receive the better we can assess the needs of your client and team.

Client Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of birth: _____/_____/_____

Team Information

Contact Person: _____ Phone: _____
E-Mail: _____

How did you learn about our services? _____

Team Member(s)	Title	Phone

Describe the Individual's Strengths _____

_____

_____

Describe the Individual's Interests _____

_____

_____

Describe the Individual's Diagnosis _____

_____

_____

Describe any applicable behavioral history (ex. aggression toward self or others, destruction of property, low frustration tolerance, etc)

_____

_____

_____

Does the individual find reading difficult, unpleasant, or laborious even though they have NOT been diagnosed with a learning disability? ☐ Yes ☐ No

Services received in the past:

☐ OT ☐ PT ☐ SLP ☐ VR ☐ AT ☐ Other_____

Services currently receiving:

☐ OT ☐ PT ☐ SLP ☐ VR ☐ AT ☐ Other_____

Sensory Information

- ☐ Blind
- ☐ Low Vision:
  - ___ Wear glasses
  - ___ Perceptual deficit
  - ___ Lighting affect vision
  - ___ Fixate on stationary object
  - ___ Look right / left without moving head
  - ___ Preference for placement of object
- ☐ Reacts to sound
- ☐ Deaf _____
- ☐ Hard of hearing _____
- ☐ Understands speech

Describe how the person communicates (ex. speech, AAC device, sign language, etc)

_____

_____